House Health and Welfare Medicaid Savings and Efficiencies Task Force
House Majority Caucus Room
Minutes
September 15, 2005

(Subject to Committee Approval)

Attendance: Chairman Block, Representatives Garrett, Henbest, Loertscher, Nielsen, and Rusche

Guests included: Senator Dean Cameron, Chuck Williams; Erik Makrush, Congressman Butch Otter Intern; Cathy McDougall, AARP; Joe Gallegos, AARP; Rakesh Mohan, Office of Performance Evaluations; Pam Eaton, Idaho Retailers Association; Steve Millard, Idaho Hospital Association; Paige Parker, Legislative Services; Paul Leary, DHW; Kent Kunz, Office of the Governor; Cathy Holland-Smith, Legislative Services; Molly Steckel, Idaho Medical Association; Teresa Molitor, Idaho Association of Commerce and Industry; Leslie Clement, DHW, Medicaid Division; Joe Crisp, IT Division, DHW; Patti Campbell, DHW

The meeting was called to order at 9:15 a.m. by **Chairman Sharon Block**, who extended a special welcome to **Sen. Dean Cameron**, Co-chair of JFAC and the Health Care Task Force Committee and invited him to sit with the committee as his input would be appreciated on these issues. She welcomed **Cathy Holland-Smith,** Legislative Financial Analyst and the new Analyst, **Paige Parker**. She welcomed guests and asked them to introduce themselves. She thanked Pamm Juker for helping in the arrangements for the meeting and Jennifer O'Kief for serving as secretary. She commented that the Medicaid system must be reformed; the Medicaid budget is unsustainable in its present increase. She thanked the committee and JFAC for all of their work and contributions.

Chairman Block shared that she has attended two national conventions this past summer focusing on Medicaid savings and efficiencies, one was the Health Chairs' Conference in Washington D.C., the other was the National Conference of State Legislatures in Seattle. Every state in the nation has had the same concerns and has implemented policies that they are realizing savings from; they are willing to share their ideas and legislation. The **Chairman** introduced **Sen. Dean Cameron.**

Sen. Cameron addressed the committee by commending them on the great job they have done in working with JFAC. He shared that he recognizes that the germane committees should be setting public policy along with JFAC and he looks forward to a great working relationship with the committee. He stated that Fiscal Year 2005 will end with a budget of $200 million which is about 10% of the overall budget, and revenue for FY 2005 is at 12.8% over the previous year. He shared that four years ago, Idaho was one of forty-six states faced with unprecedented budget gaps. This year, Idaho has been able to resolve the gap with budget cuts, one time cash reserves and the two-year temporary one-cent sales tax. Economic growth has now replaced the temporary sales tax and for now Idaho has been experiencing a structurally balanced budget and anticipates staying with this balanced budget. Much of this revenue has been driven based on a

very hot real estate and construction market, which may not continue at the same pace.

Sen. Cameron gave an account of the budget dating back to 1991, at which time the budget was $909 million; today it is in excess of $2 billion. At that time, $450 million was spent on public schools; today it is $964 million. Then 49.5% of the budget was dedicated towards public schools, today it is 46%. Then college and universities was $133 million or 14.7% of the budget, today it is $223 million but only 10% of the budget. Total education then was $651 million or 72% of the budget, today it's $1,326,000,000 or 64% of the budget. The difference of the 8% went towards Corrections and Health and Welfare. Health and Welfare in 1991 was $132 million or just under 15%. Today, it receives $407 million of general funds or 19.6%. Corrections in 1991 was $32 million, or 3.5%. Today in Fiscal Year 2005 it is $142 million, or 6.9%. **Sen Cameron** posed the question, "Where will we be fifteen years from now?" Our average annual increase in revenues has been 7% over the last fifteen years. This last year Health and Welfare was higher and has been between 12.5% and 15%. H&W can control what they pay to the providers, but what is not is shifted to the population that purchase health insurance or through other taxes.

Sen. Cameron continued by stating that the general fund appropriation for Medicaid surpassed colleges and universities in fiscal year 2003 and will surpass public school appropriations in about twelve years, based on an average increase of 12.5%. Medicaid has requested a 21.7% increase for FY 2007 on top of a $6 million supplemental for FY 2006, which will make it difficult to hold the trend at 12.5%. If we continue on this path in terms of Medicaid and Department of Corrections, the Idaho State Government will be essentially a caretaker function. By the year 2020, Idaho will spend more in Medicaid than in public schools and more in corrections than in higher education. Combined Medicaid and Corrections will be the majority of our budget. **Sen. Cameron** stated that based on this history fifteen years from now, Idaho will be spending about $1,251,000,000 in Health and Welfare. **Sen. Cameron** conveyed that he believes the Legislature has two weaknesses, one being the tendency to procrastinate any decision until politically forced to; the second is devising a magic solution to solve a problem rather than having a systemic, long-term approach, of which the latter he believes is the necessary option. Eliminating programs, capping reimbursement levels to physicians and hospitals, and capping the number of participants would be merely short-term, not long-term solutions; capping these areas will simply cost shift to the counties, the CAT fund, and those who purchase private insurance.

Sen. Cameron expressed his commitment to work with the committee to develop a long-term vision and a strategy for the future. He mentioned that other states are also sharing the same concerns of being prohibited from spending more money on public schools, natural resources, higher education, and economic development because of the money that is being spent on Medicaid and prisons. Other funding categories are the CAT Fund, indigent health care and non-Medicaid mental health care costs, substance and drug abuse treatment, child protective services, methamphetamine use, and the growth of incarceration. We will always be dealing with the uninsured and the under insured. He continued by saying that changes need to invoke behavioral change; and nothing will change unless behavior is changed. The only way to change behaviors

is to encourage and reward appropriate choices and discourage and penalize inappropriate decisions. He acknowledged the deficiency in the area of determining eligibility for benefits and that Medicaid is not traditional healthcare and cannot be completely comparable to the private sector. He closed by expressing his gratitude to the Chairman and the committee for their willingness to address this issue, but expressed his surprise and disappointment that this dilemma has not drawn more attention. **Sen. Cameron** asked **Cathy Holland-Smith** to pass out the handout prepared by Legislative Services Budget and Policy, entitled "Hypothetical General Fund Comparison of Medicaid, Universities, Public Schools and Correction," which illustrates a synopsis of the budget as he has presented (Attachment 1).

Rep. Nielsen asked if the 12.5% increase over the last fifteen years has been held down compared to the rest of the medical community because of more federal dollars coming in. **Sen. Cameron** answered that he believes that this has been a factor and that the percentage has averaged out over the fifteen years, which has held down the average. **Sen. Cameron** handed the members a handout of a copy of the Medicaid budget sheets in last year's budget book showing the overall state of the Medicaid budget for the Medical Assistance Program. The number of Medicaid clients has decreased while the actual cost has been dramatically increasing (Attachment 2).

Rep. Rusche commented that he appreciates the Senator's foresighted approach of recognizing that the Medicaid budget is only part of the larger problem with healthcare and that the 15% growth in commercial premiums has been in spite of buy-downs on benefits for constituents and clients, which have been on a per member, per month basis. He stated that when we are talking about a 12% increase in Medicaid and when we are increasing those who are eligible by 5%, we are really talking about a 7% increase in healthcare cost for the state. He further commented on his concern for pushing the cost off onto the county and hospital budgets, and the commercially insured.

Rep. Rusche asked the Senator if there have been any changes in the arena of what is allowed under federal law. **Sen. Cameron** responded by saying that the Federal Government is hearing the states' concerns and is open to new innovation more than in the past. He commented that he believes the Federal Government is looking for ways to pay less rather than pay more.

Rep. Nielsen commented that he believes that if we are going to change behaviors, we are going to have to make an impact on the pocket book and consider a method of taxation that would affect those who are abusing the system. **Sen. Cameron** responded to **Rep. Nielsen's** question regarding how he is planning to accomplish behavioral change by saying that there are no "silver bullet" solutions, but that he believes that there have not been systemic behavioral changes because appropriate behaviors have not been rewarded nor inappropriate behaviors penalized.

Sen. Cameron made some of the following points:

> He suggested that if a sales tax exemption were to be placed on food, consider placing an exemption on healthy food, such as appropriate meats and fish, fruits and vegetables instead of unhealthy food such as Twinkies, soda pop, etc.

He stated that there needs to be some mechanism of cost sharing, or co-payment.

- He stated that there needs to be developed an appropriate place where Medicaid recipients are initially treated. He added that health centers have not been adequately utilized for treating patients in the past.
- This effort will require a lot of creative, innovative individuals and all of the ideas will have criticism. Co-payments would have to be handled appropriately. The co-payment would have to be in addition to what they are already receiving.
- He has concerns about the present enrollment system, making sure that the right people who are eligible for the services are actually receiving the services.

In response to a question from **Rep. Tom Loertscher** regarding the total of short-term solutions equaling a long-term solution, **Sen. Cameron** said that he doesn't believe this would happen. He used the example that if dollars paid to providers were capped, the long-term affect would be fewer providers seeing Medicaid patients; additional cost shifting to counties, insurance companies, the general public and the CAT Fund, which would not be a savings. He used another example by saying that if growth were capped, the short-term budget year would improve, but the shift of more people onto other resources would eventually be the result.

Sen. Cameron stated that as the health insurance costs continue to rise, more employers are dropping coverage or shifting the costs to employees, who are allowing their families to go without coverage, resulting in cost shifting to Health & Welfare. He said that we have to invoke behavior change. He further stated that people must be encouraged to see the appropriate provider, refrain from smoking, overeating, drinking, and exercise. We need to consider what the healthcare system will look like in the year 2020.

In response to a question from **Chairman Block** regarding the private sector, **Sen. Cameron** stated that he believes the private sector is becoming more aware of this huge problem, but the level of understanding and concern needs to continue to be raised; the solutions have to be collaborative between the private sector, the government, local government, etc.

Chairman Block thanked the Senator and asked him if he would come back another time and address the committee regarding the Healthcare Task Force and encouraged him to join this committee. The Chairman introduced **Rep. Margaret Henbest**, Nurse Practitioner, member of the Appropriations Committee and the Health and Welfare Committee.

Rep. Henbest addressed the committee by giving an update on the Health Care Task Force Subcommittee on Mental Health. She reiterated the theory expressed by Sen. Cameron that we struggle with a problem until it becomes disastrous and are forced to act. She explained that she sits on the Healthcare Task Force and has had some experience in the legislature with the issue of mental healthcare. **Sen. Stegner** had recommended that a subgroup be formed to address this issue. The Task Force met over a year ago and came to a united consensus that there is an overwhelming concern for the mental health system in the state. That group met again on July 8,

2005. The members were asked, under the guidance of **Sen. Stegner,** to share their ideas and concerns for what needed to be addressed in the mental health system. After this brainstorming session, the second part of the meeting was a presentation from the Department of Health and Welfare (DHW) thoroughly outlining what the mental health care system of delivery is. She continued by summarizing the main items that were brought forth and discussed.

The dilemma of not addressing a problem or issue until the crisis state is realized and in turn is taken over by DHW and sometimes by the Department of Corrections.

The coalition that has been formed between the Department of Corrections and DHW regarding mental health problems within the institutions and the importance of being involved in that process.

The Idaho Medical Association's completion of a survey listing priorities with their membership as important information that the Task Force would need.

The problem of not having enough inpatient beds in state hospitals, and the disparity in location, which geographically prevents Ada and Canyon County from not having access to those beds for the mentally ill.

Involuntary assessment and holds, act teams and the number of teams and dollars that would be needed to bolster those teams.

Reviewing the statutory limits of service and particularly the issue of partial care services.

The issue of people not taking personal responsibility and not addressing their own problems, i.e., substance abuse, family conflict, etc.; and abuse of services that are provided by the Department.

Evidence based issues and the diagnosis and treatment of mental health problems and how it is a challenge in all areas of medicine, particularly in the care of the mentally ill.

The availability of services throughout the state deemed necessary for treating mental illness.

The continuum of seriousness of the disease and the necessity of having services throughout the scope of the disease rather than waiting until exacerbation and then hospitalization.

The Medicaid benefit package for the mentally ill and the need to review what services are given at certain levels, and evaluating whether or not that makes sense in the delivery of good care to the clients.

Rep. Henbest continued by highlighting some of the very comprehensive information that they received from DHW. Some of those points are the following: we spend almost $64 million of

state and federal funds for the care of the mentally ill within the Health and Welfare budget, which is about $18 million of the general fund; DHW does feel that those with severe and persistent mental illness within the state are significantly under served based on national prevalent statistics; DHW estimates that there are 6,000 people at any one time on any one day who use the system and about 12,000 who cycle in and out of the system in a fiscal year; they estimate that there are about 190,000 in the state who will have mental health problems each year and about 25,000 will be severe cases, indicating that about half will be treated. DHW is concerned that this cycling and the lack of continuity of care exacerbates the problem because the level of care is not consistent. There are other program opportunities for those not on Medicaid; for example, Family and Children's services provide non-Medicaid mental health services. They are currently serving 4000 people and have had an increase of 30% in their clientele in the last two years.

Rep. Henbest explained that she believes their next meeting will carve out prioritization of these issues and some distilling of the efforts already underway by DHW regarding transformation and efforts toward delivery of services throughout the state, and recommendations from the Idaho Medical Association, status of Corrections, and discussion of the direction the legislature should take. She welcomed questions from the committee.

Rep. Loertscher asked if the $64 million being spent on mental health per year includes monies spent in Corrections, V.A. or other organizations. **Rep. Henbest** responded by saying that these are only Health and Welfare dollars and does not include funding for Corrections, etc. or substance abuse. **Rep. Loertscher** asked if it would be possible to know what the total dollar figure is that private insurance, the V.A., Corrections, and the other organizations are spending on mental health. **Rep.Henbest** said she would take the request to the committee. **Rep. Nielsen** asked if she feels that some of these problems, such as the increase in ADD diagnosis could be decreased with behavioral change, as the Senator referred to earlier. **Rep. Henbest** responded by saying that she believes we must consider whether the accuracy of the diagnosis is correct and if the prescribed treatment and pharmaceuticals are appropriate and correct. She commented that she believes the use of legal and illegal substances exacerbates mental health and should be looked into. She shared that neuro chemical pathways in the brain can be changed by the use of illegal substances and create mental illness.

At 10:25 AM, **Chairman Block** recessed the meeting for a short break.

The **Chairman** called the meeting back to order at 10:40 AM.

The **Chairman** introduced and welcomed **Leslie Clement,** Deputy Administrator and overseer of policy from DHW, Division of Medicaid.

Ms. Clement began by providing an overview of some of the challenges facing Medicaid today and introduced some concepts leading the way to reform. She provided the members with a PowerPoint presentation which, included fourteen slides illustrating those objectives (Attachment 3), supported by a narrative (Attachment 4).

1. Modernizing Idaho Medicaid - Medicaid was originally established to serve the poorest of the poor and the most vulnerable, but has grown into one of the largest payers of health care services in the nation, which is why it needs to be reformed.

2. Medicaid in its present form is unsustainable - The National Association of State Budget Officers noted in 2004 that even after a full economic recovery is underway for state budgets, increase in Medicaid costs will far outstrip growth in state revenues into the future. Medicaid has grown on an average of 17.7% from 1987 - 2005, while growth rate in the general fund over the same period has been approximately 7.1%. Idaho has limited ability to address this escalation due to federally required eligibility categories and benefits.

3. Access, cost and quality must be balanced - Reforms based on cutting costs by reducing access and bypassing quality improvement efforts lead to higher Medicaid costs in the long run.

4. Quality and cost containment aren't either/or proposition - Idaho Medicaid will institute values-based reforms that focus on quality and access as paths to cost containment.

5. Solutions are outside traditional Medicaid parameters - Without changes in how long-term care is financed, Medicaid is likely to see significant increases in its enrollment of the frail and elderly because of the aging of the baby boomers and the impact they will have on Medicaid.

6. Medicaid operates within an interconnected health care system - Lost employer health coverage increases demand on Medicaid.

7. Approach to Medicaid reform - DHW's approach to Medicaid reforms includes five steps.

   < Identify who is covered and re-think eligibility based on needs.

   < Establish policy goals which will recognize the needs of eligibility groups and the need to responsibly steward Medicaid resources.

   < Design appropriate benefits based on beneficiaries' needs and up-to-date clinical practice.

   < Create and incorporate effective and modern delivery systems by incorporating methods from other components of the health system and in the private sector and other public systems such as the immunization program.

   < Develop more robust quality measurement and performance improvement which reflect the needs of Medicaid populations and track its performance against established policy goals.

8. Simplify eligibility to match identified needs - Redefine eligibility groups into three

categories of children, adults, and elders, recognizing the differences of those who are relatively healthy to those with special needs. Current eligibility is complex, with over forty ways to qualify for Medicaid; however, eligibility information rarely yields anything about what an individual's health care needs are.

9. Eliminate arbitrary categories that impede policy goals - Medicaid reform must bring some fairness and reason to workers with disabilities.

10. Establish policy goals relevant to specific populations - Medicaid can be more proactive by helping individuals live as independently for as long as possible by supporting informal care givers.

11. Modify benefits to meet identified needs and promote policy goals - Medicaid tends to cover the high cost benefits rather than intervening early, but reform recognizes that behavioral health and long-term care is needed and should be provided for those with special needs.

12. Alter delivery systems to effectively meet needs and program goals - Medicaid reform must incorporate tools used in the private sector to be able to negotiate best price for volume.

13. Alter delivery systems to effectively meet needs and program goals.

14. Match quality/performance improvement to populations served - Reviews have shown that some information is not tracked and performance indicators are not reported; consequently, systems must be established to track our progress.

Ms. Clement concluded her overview and welcomed questions. She responded to **Rep. Henbest's** question regarding where they are at this point by saying that they have met with Chairman Block, Sen. Compton, Kathy Holland-Smith and have taken this basic framework to the centers for Medicaid and Medicare in Baltimore this past summer with their reform proposals. It was recommended that they put together a concept paper that will be submitted next month. DHW has assigned staff some reform assignments to make changes in the state plans, identify all of the different types of waivers needed, focus on healthy children/working adult population, address prevention services, health risk assessment, some of the tools to pursue selected contracting and financial arrangements, and submit a formal proposal to CMS, Center for Medicare and Medicaid Services, by the end of December, 2005. At that point they will engage in a negotiation session, working through the business processes, initiate public hearing, and training. She said they hope to have final approval in place by July of 2006. She said that they think this kind of effort will take five to eight years to fully address all of the needs of the population.

Ms. Clement accepted **Rep.Loertscher's** request to keep the Task Force informed of their progress through this process by saying she would like to have assistance from the committee in terms of what are appropriate policy goals and performance measurement standards.

In response to a question from **Rep.Nielsen** who remarked that this approach appears to be one of prevention, **Ms. Clement** agreed by saying that the emphasis is in getting ahead of the issue before it becomes acute. **Rep. Nielsen** also said that this seems to be a long-term approach and could also effect the behavioral issue.

Rep. Henbest asked for an update regarding the out dated computer systems, etc. **Ms. Clement** said there is currently a process in place to replace the current eligibility system which is very archaic in its management capability. She further explained their current endeavor of determining where a person of eligibility would fall into a specific population group. For example, by determining eligibility in one area and placing that person/persons into the healthy children/working adult group and defining what services are being paid for in each group, which costs are reasonable and which seem too high.

Ms. Clement responded to **Rep. Loertscher** who questioned the graph at the bottom of page 3 of the handout (lost employer health coverage increases demand on Medicaid) illustrating the children's population as only at 1.6% for the uninsured in spite of CHIP. She explained that this chart shows that after CHIP stepped in with coverage, there was still 1.6% who didn't meet the eligibility requirements and were not insured as a result of lost employer coverage.

Ms. Clement yielded to **Senator Cameron's** question regarding time frame on the EPICS and Maine systems by saying that she is not sure on the EPICS time frame and yielded to **Patty Campbell** from DHW who explained that they are still in the evaluating stages. The Maine system may not be transferable and they may be building a system from within. **Ms. Clement** responded to **Chairman Block's** question regarding estimate of cost and when that would occur in the fiscal budget by explaining that they don't have precise numbers yet, but they have begun to identify the initiatives and are in the predicting stage.

Chairman Block welcomed **Joe Crisp**, Information and Technology Services Division Manager of DHW, who addressed the committee in the absence of Randy May who was out of town. Mr. Crisp gave an update on the Medicaid Management Information System. He began by explaining that DHW has spent the last year researching what type of system the Department needed and looked at other states to see what was available that would support the systems indicative to Idaho. They conducted several sessions in Boise, inviting vendors to come and demonstrate their systems. After traveling throughout the state, they gathered 930 detailed requirements necessary to support the delivery system that Health and Welfare provides. After their research, was completed, they discovered that there were already existing systems to fill the need, avoiding the cost and time required to build from scratch. The RFP, Request for Proposal, was sent out May 26, 2005, indicating the deadline for proposals to be received by July 26, 2005. Three proposals have been received from the following vendors:

- EDS - Texas
- Noridian - North Dakota
- UNISYS - Virginia

There were twenty-four total evaluators broken into six groups who spent five and one-half weeks scoring the written proposals and then observing the oral presentations and demonstrations from the three vendors. The Department is presently evaluating and scoring each vendor's proposal and will not have cost estimates until the process is finished. **Mr. Crisp** listed some of the attributes of the proposed system:

- Benefit packages will be created in less than a month, prior packages could take up to a year.
- Reimbursement for professional services will be more efficient in determining what is being provided and what is being paid.
- Correct Coding Initiative (CCI) will give assurance that providers are being reimbursed most cost effectively and efficiently for the state.
- A Medicaid community web portal will be implemented which will forego using electronic data interchange clearing houses that charge per claim.
- Remittance advice will be disbursed and distributed through the web portal; currently they are printed and mailed.
- Prior authorization and referral processing will be able to be submitted with a response back indicating approval or disapproval of that authorization.
- Web based training will be provided.
- Disease management decisions - will be able to bring data in on a national level and compare how Idaho is doing with national trends; will be able to target preventive care and observe if participants are following through with their plan of care.
- Electronic document management - essentially eliminating unnecessary paper and labor for organizing and recording information.

Mr. Crisp stated that in late October or November they will negotiate a contract that will be presented to CMS for approval. He welcomed questions from the committee.

Rep. Henbest commented that in the past there have been other agencies that have pursued computer systems, that tens of thousands of dollars later do not work, and the money is lost. She asked if he has confidence that this system has worked well in other states and will be adaptable to Idaho. He assured her that one of the primary requirements of the proposals was that any of the systems that were going to be proposed had to be in production in some other state.

In response to **Rep. Nielsen's** concern regarding having to continually update new implementation at a great cost, **Mr. Crisp** said that there will be a maintenance contract to keep enhancing the system, keeping it current for upcoming years.

In response to **Sen. Cameron's** question, **Mr. Crisp** said there were about a dozen different companies that were targeted, and the reason ACS did not bid was because of the requirement that the system had to already exist as of the date the proposals were due.

Mr. Loertscher asked if **Mr. Crisp** has actually seen these systems working in these other states. **Mr. Crisp** explained that they have, and that part of the requirement was that the vendors had to demonstrate the system by connecting directly into the actual environment showing the system operating on the computer system from that location from which it had been proposed. **Mr. Crisp** responded to **Chairman Block's** question regarding the issue of fraud being addressed in this system by saying that there are components that will allow them to tailor reporting to identify instances of fraud on both the clients and providers side. **Mr. Crisp** answered **Chairman Block's** question regarding the system's capability of interfacing within the Department and throughout the regions by saying that this is one of the requirements. He explained that the process will have an immediate response. **Chairman Block** asked when the fiscal impact will affect the budget, in what budget year. He said that he it would be this budget year.

Cathy Holland-Smith yielded to **Sen. Cameron's** question of what the dollar amount of the supplemental request for the FY 2006 budget by saying that at this time there is a placeholder/estimate and the supplemental is for $7.4 million spending authority and of that $756,000 would be general funds. In addition, there is a request for additional funding for FY 2007 for $21.5 million of which $2.1 million would be general fund. **Sen. Cameron** asked how long are we availed to a 90/10 match. **Ms. Holland-Smith** said that it has been her understanding that as long as this project is active, the 90/10 will remain.

Chairman Block adjourned for lunch at 11:50 AM.

Chairman Block called the meeting to order at 1:26 PM. She introduced **Rep. Kathie Garrett** acknowledging her extensive expertise and background in the healthcare field.

Rep. Garrett presented the committee with an update on the Medicare Part D Prescription Drug Program. She began by stating that this new Medicare prescription drug coverage will be one of the biggest programs ever established by Medicare. She provided the committee with several pieces of literature for their assistance in getting the message out to their constituents:

- Attachment 5a - a brochure titled, "What You Need to Complete the Application"
- 5b - a brochure titled, "Medicare Rx Prescription Drug Coverage"
- 5c - a fact sheet of commonly asked questions and a list of contacts
- 5d - a sheet titled, "A Drop in Article for Your Newsletter"
- 5e - an information yellow sheet titled "Medicare Prescription Drug Coverage"

Rep. Garrett stated that Idaho has 194,000 seniors and disabled people who are eligible for

Medicare and if they are eligible for Medicare they will be eligible for this program. There are 17,000 with dual eligibility having Medicaid and Medicare coverage. She attended a Governors' association meeting in Chicago and has attended several presentations by CMS. One of the things she has learned is that by federal law the employer has to notify their employees as to whether their insurance plan is credible or not, equal to the Medicare plan. Consequently, the state as an employer has the responsibility of getting notification letters out to everyone by November 14, 2005. She clarified that this is an insurance plan with a premium, co-pay, and a deductible; it is not a Medicare benefit.

Rep. Garrett described some of the coverage factors as they are listed on the yellow sheet (5e). The program will cover FDA approved drugs, brand names and generic drugs. It does not cover over-the counter drugs, vitamins, barbiturates, benzodiazepines, which may be subject to change. CMS has said that there will be approximately nineteen plans to choose from, of which four will be national plans; the cost of premiums will range from below $20 to an average premium of $32. On October 1, 2005, the "floodgates" will open and the 194,000 eligible (and many vulnerable) citizens will be contacted by numerous vendors trying to sell their plans. As shown on the graph (5e), she referred to the area of prescription drug spending in the category of those who will spend $2,250 to $5,100 and will receive no benefit as the "donut hole." She explained that CMS's explanation is that the average senior pays below $2,100 per year for prescription drugs. Those spending over $5,100 receive 95% coverage. The plans cannot discriminate and cannot rule out those with preexisting conditions. **Rep. Garrett** noted the guidelines for coverage based on those in low-income brackets, explaining that premiums can range from no premium to a sliding scale basis; the deductible can range from no deductible to paying a maximum of $50; the co-pay can range from $1 to $5; and there is no coverage gap.

Rep. Garrett noted important dates:

- October, 2005 - Plans become public
- Rx Drug Plan finder Tool available online, which is difficult for many seniors
- November 15, 2005 - First day to enroll in drug plan
- January 1, 2006 - Drug coverage begins
- May 15, 2006 - Last day to enroll in a plan, and cannot enroll until the next open enrollment period which will be every year from November 15 to December 31.

There will be a 1% penalty fee per month on the monthly premium for every month after May 15, 2006 that an individual does not enroll. If the individual decides to enroll at a later enrollment date, his/her premiums will be assessed accordingly.

Rep. Garrett stated that the Governor, the Department and she believe that they have the responsibility to reach as many of those 194,000 Idaho citizens because of the significant financial impact there could be to seniors. She has formed a steering committee, working with many partners such as AARP and St. Vincent De Paul to assist in helping with the application

process, etc. A region strategy planning group has been formed and charged with convening groups to help assist seniors throughout the state in selecting and enrolling in a plan. **Rep.Garrett** stated that CMS has been very clear that this is the state's responsibility to get the word out and assist the citizens.

Rep. Garrett had previously been asked by **Chairman Block** to address the impact this program will have on Medicaid. **Rep. Garrett** gave some of the estimated projections from the Department which are at this point 194,000 Medicare eligible, 17,000 dual eligible. CMS estimates that there will be an additional 7,000 new people on the Medicaid roles who will enroll next year. The Department is looking at additional staff to assist in implementing this new program. They are looking at a contract with Idaho State University School of Pharmacy to assist the 17,000 dual eligible to help navigate the best formula for those individuals who are taking multiple medications. The Department will be asking for an additional $3.4 million. She gave figures of $40 million of savings to Medicaid; however the federal government will require approximately $12.5 million reimbursement. **Rep. Garrett** concluded her presentation and welcomed questions from the committee.

Rep. Henbest asked if an insurance company could drop prescriptions or change a benefit in mid-stream. **Rep. Garrett** answered by explaining that the pharmacy can change benefits within the period, but has to give 60 days notice and has to show justification to CMS. She further explained that the person already on that prescription can appeal and get their prescription covered but cannot enroll in another plan before the next open enrollment. **Rep. Henbest** commented that she finds this very alarming that Congress has given the insurance company 60 days and has saddled the participant with twelve months. **Rep. Henbest** asked if insurance plans currently covering individual retirees from the state or the private arena were to cancel coverage in the future, would they be penalized down the road for not enrolling in this new Medicare coverage now. **Rep. Garrett** said they would not, however, they must enroll within 63 days from the time their coverage is cancelled.

In response to a **Rep. Nielsen's** question, **Rep. Garrett** said that there is no guarantee that in four or five years the federal government will not pass the cost of this program onto the state. She also said that CMS has said that there will be changes to this plan in the future. **Rep. Garrett** encouraged the committee to get the message out everywhere they can, their churches, civic events, etc. **Chairman Block** stated that she had received information indicating that the $3.4 million is for FY 2006. She yielded to **Cathy Holland-Smith** to share with the committee some additional funding information. **Ms. Holland-Smith** stated that along with the $3.4 million impact beginning in FY 2006, there will be an additional $12.6 million impact in FY 2007 for a total impact by next year of $16 million to the general fund based on current estimates for Medicaid Part B.

Chairman Block had the secretary pass out two handouts, 1) a copy of the 2005 House Health and Welfare Committee Budget Report to the Joint Finance and Appropriations Committee, prepared by Chairman Block, (Attachment 6); and 2) a list of ideas of legislation that are being implemented by other states that she gathered while attending the conferences in Washington

D.C. and Seattle (Attachment 7). She asked the members to note that JFAC has implemented the supplemental and enhancement requests for FY 2005 and FY 2006 as shown on pages 2 and 3. She has asked **Kathy Holland-Smith** to give a report on some of the items at the October meeting. She encouraged the members to review the report as the issues will be discussed further in the October meeting. The Chairman guided the members through the second handout, highlighting some of the ideas from the list:

1. Focus on incentives to encourage personal responsibility
2. Seek more flexibility with federal government regulations, become less dependent on waivers
3. Develop innovative programs with solutions for Long Term Care
4. Create public/private partnerships to expand access to health care coverage
5. Implement cost sharing measures
6. Implement emergency room screening/triage
7. Investigate fraud and abuse
8. Evaluate programs by asking for a Legislative Audit of programs for DHW
9. Re-enrolling of Medicaid clients
10. Access inefficiencies in service delivery
11. Simplify and streamline administration of programs
12. Re-evaluate optional services and eligibility criteria
13. Create purchasing pools
14. Partner with other states to purchase prescription drugs
15. Use private sector techniques
16. Consider Pay-for-Performance measures
17. Make more use of small health clinics
18. Use physician assistants, nurse practitioners and public health nurses rather than physicians
19. Implement electronic records to control costs and simplify programs
20. Implement health savings accounts
21. Incorporate care management and managed care programs

22. Implement disease management programs

23. Improve the coordination between Medicaid and Medicare

24. Ask the federal government to assume more responsibility for dual eligibles

25. More adequately address substance abuse

26. Emphasize preventive health care

27. Provide incentives for preventive health care and life style choices

28. Establish workforce development policies

29. Provide opportunities for more employment for the disabled

Chairman Block invited comments from the committee. **Rep. Nielsen** made the suggestion of having the state contract with private insurance carriers on a basis where the state helps to pay for the premium and the recipient makes the co-payment. Allowing a plan for a Medicaid recipient to more parallel the private insurer's plans would cause the recipient to take on more of the responsibility. **Chairman Block** commented that other states are reimbursing providers for unpaid co-payment amounts. She also commented that about 75% of people in the states who have co-payments are paying. **Rep. Henbest** shared her concern for those paying for ten or more years for long-term care insurance and then have the insurance company decide to drop the coverage. She suggested the Department of Insurance provide information about the current status of the long-term care industry before efforts are made for tax incentives for buying certain products. **Rep. Garrett** commented that the Department of Administration is looking at ways to use sick-leave for state employees toward long-term care when they retire.

Rep. Rusche commented that he would find it useful to get additional information from Rep. Garrett or Medicaid on cost per member or cost per unit; number of units of service per member by various categories, young families, the aged, disabled. He believes that these factors would be helpful in knowing whether to attack utilization or eligibility. **Leslie Clement** said that the Department would provide that information. **Rep. Henbest** agreed to check with the Department of Insurance to find information regarding the long-term care insurance issue. **Rep. Nielsen** commented that he does not see behaviors changing, in spite of some of the incentive programs provided. He believes that a more direct approach through a method, such as taxation, would be more effective toward achieving behavioral change.

Rep. Rusche commented that although health promotion programs are laudable goals, he believes that the approach needs to be more towards the system of care and what we deliver, and who we deliver it to.

Chairman Block thanked everyone and asked them to return with ideas and suggestions for presentation at the next meeting in October. The committee agreed to have the meeting on October 27, 2005. The meeting was adjourned at 2:40 P.M.

Representative Sharon Block
Chairman

Jennifer O'Kief, Secretary